Community Services Board/Behavioral Health Authority: ____________________ Consumer ID# ____________

Date: ____________ Time: From ________ ☐am ☐pm To________ ☐am ☐pm
Time under court order: ________ Time not under court order: ________

Emergency Custody Order: ☐Yes ☐No ☐Magistrate Issued ☐ Law Enforcement Issued (Paperless)
Date and Time Executed: ____________
Extension: ☐Yes ☐No Reason: ____________________ (identify facility/medical evaluation/other good cause)
Evaluation: ☐ In-person or ☐ Two-way electronic video and audio
Petitioner ____________________ Phone: ____________
Translator and language: ____________________ Phone: ____________

**DISPOSITION** ☐Recommitment ☐TDO ☐Voluntary ☐CSU ☐ Safety Plan ☐Release ☐Referral ☐Other ________

**HOSPITAL/FACILITY** ____________________ Case/TDO #: ____________

## Personal Information

First Name: ____________ Middle: ________ Last Name: ____________ DOB: ________ Age: ____

SSN: ______ - _____ - ______ M / F ________ ________ ____________
(Gender) (Race) (Hispanic Origin) (Height) (Weight) (Hair Color) (Eye Color)

Address: ________________________________________
(Street) (City) (State) (Zip Code) (County)

Phone: (___)____________Home/Cell Marital Status: ________ Spouse Name: ____________

School Division (If applicable): ____________ School Attending: ____________Grade: ________ Special Ed.: Y or N

(If under age 18)
Mother: ____________ Address: ____________ Phone: ____________ Home/Cell

Father: ____________ Address: ____________ Phone: ____________ Home/Cell

Legal Custodian ☐ Unknown Name: ____________Phone: ________Address:____________
Legal Guardian ☐ Unknown Name: ____________Phone: ________Address:____________

Emergency Contact: Name ____________Relationship to Person: ________ Phone ____________

Address: ________________________________________
(Street) (City) (State) (Zip Code) (County)

CSB of Residence: ____________________

CSB Code: ________Contacted: ☐Yes ☐ No ____________________
(Name) (Phone)

Employment Status: ☐ Unknown____________ Education Level: (All ages)____________
Employer: ____________________Phone: ____________
Military Status: ☐ Unknown ____________Start Year: ________ End Year: ________
SSI ☐Yes ☐ No ☐ Unknown SSDI ☐Yes ☐ No ☐ Unknown

**Medicaid:** ☐Yes ☐ No ☐ Unknown # ____________Subscriber Name: ____________

**Medicare**: ☐Yes ☐ No ☐ Unknown # ____________ Part D: ☐Yes ☐No ____________Plan

**Insurance**: ☐Yes ☐ No ☐ Unknown ____________________
(Name of Company/ Group/Plan/Number)

**Local Use**

Name: ____________

**Collateral Sources**

☐ Individual Requesting Evaluation ☐ Family/Significant Other/Guardian ☐ Treatment Records
☐ Treating Physician/Psychiatrist ☐ CSB Case Manager or Other Staff ☐ Police/First Responders
☐ CIT Officer ☐ WRAP Plan ☐ Advance Directive ☐ Safety & Support Plan

Is CSA (Comprehensive Services Act) involved with minor? ☐Yes ☐ No ☐ Unknown

Is Department of Social Services involved with individual? ☐Yes ☐ No ☐ Unknown

Comments:_______________________________________________

_______________________________________________

**Presenting Crisis Situation**

Referral Source: ______________________ Consultation Location: ______________________

Reason for Referral: _______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Assessment:

_______________________________________________

## Behavioral Health Treatment/Services

**Current Outpatient Treatment**: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services

☐ Private Provider or ☐ CSB Name: ______________________ Phone: ______________________

Case Manager: ______________________ Phone: ______________________

Psychiatrist: ______________________ Phone: ______________________

**Prior Inpatient Treatment**: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services

Name/Location of Last Tx facility: ______________________ Adm. Date: _______ Discharge Date: _______

Number of Hospitalizations: _______

Ever in a State facility? ☐ Yes ☐ No Name: ______________________ Date: ______________

Ever in a Crisis Stabilization Unit? ☐ Yes ☐ No Name: ______________________ Date: ______________

Other: ______________________________________________

☐ WRAP Plan ☐MOT ☐ PACT/ICT ☐ NGRI ☐ Advance Directive ☐ Safety & Support Plan ☐ Group Home
☐ Day Treatment ☐ Prevention Services ☐ In-Home Provider Name: ______________________ ☐ Other: ______________

## Substance Abuse Assessment

☐ No current use ☐ No history of use ☐ Refuses to answer

Current use listed below:

| Drug Type | Priority | Age 1st Use | Frequency of Use and Amount | Method of Use | Date of Last Use and Amount |
|---|---|---|---|---|---|
| | Primary | | | | |
| | Secondary | | | | |
| | Tertiary | | | | |

History of substance abuse ☐ (Drugs, alcohol, mood altering substances, marijuana, prescription medications, inhalants)

Comment: ______________________________________________

______________________________________________

______________________________________________

Have you or anyone else ever felt you had a drug or alcohol problem? ☐ Yes ☐ No

Have you received inpatient or outpatient SA treatment? ☐ Yes ☐ No Maintenance services? ☐ Yes ☐ No

Number of prior episodes of any drug: __________ Detoxification treatment? ☐ Yes ☐ No

Name/Location of last treatment facility: ______________________ Date of Discharge: ______________

| | **Current** withdrawal (Past 24 hours) | **History** of withdrawal |
|---|---|---|
| Tremors | | |
| Headaches | | |
| Vomiting (Blood present) ☐ Yes ☐ No | | |
| Nausea | | |
| Diarrhea (Blood present) ☐ Yes ☐ No | | |
| Sweating | | |
| Paranoia | | |
| DT's | | |
| Other | | |

BAC: ______________ Time: ________ Lab Results: ______________________ ☐ Unable to Test

Tobacco use? ☐ Yes ☐ No Type: ______________________

Pregnant Status: ☐ Yes ☐ No ☐ Unknown Pregnant and using substances? ☐ Yes ☐ No ☐ Unknown

Name: ______________________

**Mental Status Exam**

Appearance: ☐ WNL ☐unkempt ☐poor hygiene ☐ tense ☐ rigid

Behavior/Motor Disturbances: ☐ WNL ☐agitated ☐guarded ☐tremor ☐manic ☐impulsive ☐psychomotor retardation ☐ tearful ☐easily startled ☐distracted ☐hysterical ☐ restless

Orientation: ☐ WNL ☐ Disoriented to: ❍time ❍place ❍person ❍situation

Speech: ☐ WNL ☐ pressured ☐ slowed ☐soft ☐loud ☐slurred ☐ incoherent

Mood: ☐ WNL ☐depressed ☐angry ☐hostile ☐euphoric ☐anxious ☐anhedonic ☐withdrawn

Range of Affect: ☐ WNL ☐constricted ☐blunted ☐flat ☐labile ☐inappropriate

Thought Content: ☐ WNL ☐impaired ☐unfocused ☐unreasonable ☐preoccupation ☐delusions ☐thought insertion ☐grandiose ☐ideas of reference ☐paranoid ☐obsessions ☐phobias

Thought Process: ☐ WNL ☐ illogical ☐abstract ☐concrete ☐incoherent ☐ perseverative ☐impaired concentration ☐ loose associations ☐ flight of ideas ☐circumstantial ☐blocking ☐tangential

Sensory: ☐ WNL ☐ illusions ☐ flashbacks ☐ Hallucinations: ❍auditory ❍visual ❍olfactory ❍ tactile

Memory: ☐ WNL ☐ Impaired: ❍ recent ❍ remote ❍ immediate

Appetite: ☐ WNL ☐ increased ☐decreased Weight: ❍ stable ❍ loss ❍ gain

Sleep: ☐ WNL ☐ hypersomnia ☐onset problem ☐ maintenance problem

Insight: ☐ WNL ☐ blaming ☐little ☐ none

Judgement: ☐ WNL ☐ impaired ☐ poor

Estimated Intellectual Functioning: ☐Above average ☐ Average ☐Below average ☐Diagnosed MR ☐Unable to determine

Able to provide historical information: ☐ Yes ☐ No Explain: ______________________________

Reliability of self report ☐ Good ☐ Fair ☐ Poor Explain: ______________________________

**Significant Clinical Findings** (further describe any symptoms checked above)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Name: ______________________

**Medical**

Primary Care Provider: ______________________________________________ Phone: ____________________

Medical history and current medical symptoms or issues:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Medication: **Please see attached medication list** ☐ **Please see attached medical addendum** ☐

Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

| Name | Dose | Schedule | Physician |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

Has individual followed recommended medication plan? ☐ Yes ☐ No Explain: ______________________

Has individual followed recommended recovery plan? ☐ Yes ☐ No N/A ☐ Explain: ______________________

Recent medication change? ☐ Yes ☐ No ☐ Unknown Date of change: ______________________

Describe change: ____________ ______________________________________________

Allergies (including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown

Describe: _______________________________________________________________

_______________________________________________________________________________

**Legal Data**

Legal Status: ____________________ ☐ Unknown

Is individual serving a sentence? ☐ Yes ☐ No ☐ Unknown Details: ______________________

Is individual NGRI Conditional Release? (Adults only) ☐ Yes ☐ No ☐ Unknown Details: ______________________

Is individual on probation or parole? ☐ Yes ☐ No ☐ Unknown Contact Person: ______________________

Pending legal charges? ☐ Yes ☐ No ☐ Unknown Charges: ______________________

Date of hearing if known: ____________________ Court of Jurisdiction ______________________

If a minor: Judge: ____________________ Attorney: ____________________ GAL: ____________________

Has individual come from detention? ☐Yes ☐ No ☐ Unknown

Juvenile Detention Center: ______________________________________________

(Facility Name) (Address) (Telephone) (Fax)

**Diagnosis DSM IV R** (P- Provisional, H-Historical)

Axis I ____________________ Axis I ____________________ Axis I ____________________

Axis II ____________________ Axis II ____________________

Axis III ______________________________________________

Axis IV Psychosocial and Environmental (Check all that apply) ______________________

☐ Support group ☐ Social /Environmental ☐ Educational ☐ Domestic ☐ Occupational ☐ Housing ☐ Economic

☐ Health Care ☐ Legal System ☐ Other ______________________

Axis V GAF Current: __________ Highest past year, if known: __________

**Individual Service Planning**

Individuals who may be helpful in treatment planning.

| | Name | Telephone | Relationship |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

☐ Family Member ☐ Guardian Name:______________________________may be contacted with information that is directly relevant to their involvement with the individual's health care, including location and general condition. (32.1-127.1:03(D34))

☐ Individual agrees ☐ Individual lacks capacity

☐ Individual objects ☐ Emergency makes it practically impossible to agree or object.

**Outcome of the emergency evaluation or ECO** ☐

No further treatment required, or

☐ Individual declined referral and no involuntary action taken, or ☐

Referred to voluntary crisis stabilization unit, or

☐ Referred to voluntary outpatient or community treatment other than crisis stabilization, or ☐

Referred to voluntary inpatient admission and treatment,

and

☐ Petitioner and ☐ Treating physician notified of disposition if TDO not recommended. ☐

Recommitment recommended by CSB

☐ TDO recommended by CSB

☐ Hearing and commitment process has been explained to the individual.

CSB consulted with magistrate about alternative transportation ☐ Yes ☐ No

☐ CSB does not recommend alternative transportation.

☐ CSB recommends alternative transportation by ______________________________.

(Name)

37.2-805.1

☐ Consideration of 10 day inpatient admission by health care agent pursuant to advance directive ____________________.

(Name of Agent)

☐ Consideration of 10 day inpatient admission by designated guardian pursuant to guardianship order____________________.

(Name of Guardian)

**Risk Assessment/Clinical Options**

**Minor 16.1-340.1**
Because of mental illness:
☐ The minor presents a serious danger to ☐self or ☐others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or
☐ Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, as evidenced by: ☐delusional thinking or ☐by a significant impairment of functioning in hydration, nutrition, self protection or self control; and
☐The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.
Findings:______________________________________________________________________________

_______________________________________________________________________________________
The minor's parents/guardians ☐were or ☐were not consulted. The minor's treating or examining physician, if applicable,
☐ was or ☐was not consulted.

Treatment and support options:
Inpatient treatment ☐is or ☐is not the least restrictive alternative that meets the minor's needs ☐
Outpatient or less restrictive services has been tried with the following results:

_______________________________________________________________________________________

_______________________________________________________________________________________
☐ Outpatient or less restrictive service has *not* been tried and is *not* likely to be adequate because:

_______________________________________________________________________________________

_______________________________________________________________________________________

**Adult 37.2-809**
It appears from all evidence readily available that the person:
☐ Has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future:
☐ Cause serious physical harm to ☐ self or ☐ others as evidenced by recent behavior, causing, attempting, or threatening harm, and other relevant information, or,
☐ Suffer serious harm due to his lack of capacity to:
☐protect himself from harm or
☐provide for his basic human needs (not applicable under Virginia Code 19.2-169.6), and

☐ Is in need of hospitalization or treatment.

Findings:______________________________________________________________________________

_______________________________________________________________________________________

**Capacity for adults and minors age 14 and older**

| | | | | | |
|---|---|---|---|---|---|
| Able to maintain and communicate choice | ☐ Yes | ☐ No | Able to understand consequences | ☐ Yes | ☐ No |
| Able to understand relevant information | ☐ Yes | ☐ No | Willing to be treated voluntarily | ☐ Yes | ☐ No |

**Risk Factors**
☐ Aggressive behavior ☐ Sexual acting out ☐ Self injurious behavior ☐ Elopement ☐ Actively psychotic
☐ Suicidal ideation ☐ Homicidal ideation ☐ Plan ☐ Access to weapons
☐ Other ______________________________________________________________________________

**Protective Factors** _________________________________________________________________

_______________________________________________________________________________________

**Final Disposition:**

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

| Preadmission Screening Evaluator Signature | Date | Board | Preadmission Screening Evaluator Signature | Date | Board |
|---|---|---|---|---|---|
| Electronically signed ☐ | | | Electronically signed ☐ | | |

Name: ______________________________

Print Name Here (not required if electronically signed) Print Name Here (Not required if electronically signed)

**CSB report to court and recommendations for the individual's placement, care and treatment pursuant to 16.1-340.4 (Minor) or 37.2-816 (Adult)**

Name of Individual: ________________________________ Date: __________ Time: __________ ☐am ☐pm

☐ No further treatment required.

☐ Has or ☐ does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for Outpatient treatment) ☐ Is or ☐ is not willing to be treated voluntarily (* not applicable under Virginia Code19.2-169.6)

☐ Voluntary community treatment at the ☐ CSB (specify) ________________________________

Or ☐ other (specify) ________________________________

☐ Voluntary admission to a crisis stabilization program (specify) ________________________________ ☐ Adult: Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of treatment up to 72 hours and will give the facility 48 hours notice to leave in lieu of involuntary admission.

☐ Minor: Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.

☐ Minor: Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

**Minor 16.1-340.4** ☐ Under age 14 ☐ Age 14 or Older

Parent or guardian ☐is or ☐is not willing to consent to voluntary admission (for inpatient treatment only)

☐ **Because of Mental Illness meets the criteria for involuntary admission or mandatory outpatient treatment as follows:**

☐ The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidence by recent acts or threats or: ☐ Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: delusional thinking or significant impairment of functioning in: ☐hydration ☐nutrition ☐self protection ☐ self control. ☐ The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment. Is the parent or guardian with whom the minor resides willing to approve any proposed commitment?
☐ Yes ☐ No ☐ Unavailable

If no, is such treatment necessary to protect the minor's life, health, safety or normal development? ☐ Yes ☐ No

❖**Therefore the CSB recommends:**

A. ☐ Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment.
☐ Alternative transportation

B. ☐ Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and ☐ providers of the services have agreed to deliver the services: The minor, if 14 years of age or older, and his parents or guardians ☐have sufficient capacity to understand the stipulations of the minor's treatment, ☐ have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and ☐ are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and ☐ the ordered treatment can be delivered on an outpatient basis by the Community Services Board or a designated provider(s): specify:________________________________

C. ☐ Do the best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment? ☐Yes ☐No

**Adult 37.2-816**

☐ **Because of Mental Illness** meets the criteria for involuntary admission or mandatory outpatient treatment (* not applicable under Virginia Code19.2-169-6)as follows:

☐ There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any, or

☐ There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to lack of capacity:
☐ to protect him/herself from harm or
☐ to provide for his/her basic human needs (* not applicable under Virginia Code19.2-169.6).

❖Th**erefore the CSB recommends:**

A. ☐ Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment.
☐ Alternative transportation

B. ☐ Mandatory outpatient treatment (37.2-817 (D) )because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐ are deemed to be appropriate; and the person ☐ has agreed to abide by his/her treatment plan, and ☐ has the ability to do so. The recommended treatment ☐ is actually available on an outpatient basis by the ☐ CSB or ☐ designated provider(s) specify: ________________________.

**C.** ☐ Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817 (C1) and (C2). ☐The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission ☐ in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; ☐ as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment, and ☐ the person is likely to benefit from mandatory outpatient treatment.

________________________________ ________________________
Preadmission Screening Evaluator Signature or Electronically signed ☐ Date Board

________________________________ ________________________
Print Name Here (Not required if electronically signed) Representative CSB

**Personal Comment Section**

As appropriate, the individual receiving emergency services shall be offered the following opportunity to comment at the time of the preliminary evaluation and prior to the commitment hearing. If a minor, the parent or guardian may also comment.

☐ Individual
☐ Parent/Guardian
☐ Family member

☐ Yes (see comments below)
☐ Yes and does not choose to comment
☐ No, Explain: ______________________________

How would you describe the current situation?

______________________________
______________________________
______________________________

Are there things you've already tried to help manage the current situation?

______________________________
______________________________
______________________________

What do you think would be the most helpful to you right now?

______________________________
______________________________
______________________________

**If parent/guardian of minor:** What do you think would be most helpful to your child right now?

______________________________
______________________________
______________________________

Are there any particular people you would like to be involved in your care and treatment (such as family members, friends, or peers)?

______________________________
______________________________
______________________________

**If parent/guardian of minor:** Are there particular people you would like to be involved in your child's care and treatment?

______________________________
______________________________
______________________________

What are your top three strengths?

______________________________
______________________________
______________________________

**If parent/guardian of minor:** What are your child's top three strengths?

______________________________
______________________________
______________________________

Would you like to comment on anything else?

______________________________
______________________________
______________________________

Individual's Signature: ______________________________ Date: ____________

Parent/Guardian/Family Member Signature: (if appropriate) ______________________________ Date: ____________

Name: ______________________________

**Prescreening Supplement**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Name: ___________________________